# SERVICE SPECIFICATION

| | |
|---|---|
| **Service** | Palliative Care Co-ordination Centre |
| **Commissioner Lead** | |
| **Provider Lead** | |
| **Period** | The Palliative Care Coordination Centre will act as a single point of access for organising a variety of services including packages of care; information on services; and management information on demand and capacity of services. The centre will also be responsible for the maintenance of a locality palliative care register. |

## 1. Purpose

### 1.1 Aims

The aims of the service are to:
Improve the co-ordination and provision of packages of care for patients at the end of life and their families to enable them to be cared for and die in the place of their choice.

The service will work as an integrated part of health & social care provision throughout your locality effectively managing resources to ensure equity of access to services, equity of available services, and value for money. It will provide management information on service utilisation and maintain the locality palliative care register.

### 1.2 Evidence Base

This Commissioning Specification is designed to ensure that ____________________ purchase an Palliative Care Co-ordination Service that will deliver the outcomes set out within.

- NICE Quality Standard - http://www.nice.org.uk/guidance/qualitystandards/endoflifecare/home.jsp
- NICE Guide for commissioners on end of life care for adults - http://www.nice.org.uk/usingguidance/commissioningguides/endoflifecare/endoflifecareadults.jsp
- NHS operating framework 12/13 - http://www.dh.gov.uk/health/2011/11/operating-framework/
- Palliative Care Funding Review - http://palliativecarefunding.org.uk/wp-content/uploads/2011/06/PCFRFinal%20Report.pdf
- Advance Care Planning: A guide for Health and Social Care Staff, University of Nottingham (February 2007)
- The Preferred Priorities for CareEnd of Life Programme, December 2007
- Gold Standards Framework www.goldstandardsframework.nhs.uk
- Prognostic Indicator Guidance (June 2006) www.goldstandardsframework.nhs.uk
- The 5 Priorities for Care, as implemented locally.
- Department of Health. New Deal for Carers. 2007. www.dh.gov.uk
- Department of Health Transforming Community services (2009)
- NHS Institute for Innovation and Improvement The Productive Ward www.institute.nhs.uk/productiveward
- NHS Institute for Innovation and Improvement The Productive community www.institute.nhs.uk/productivecommunityservices
- NHS Institute for Innovation and Improvement The Productive Community Hospital www.institute.nhs.uk/productivecommunityhospital

It is also intended to support the delivery of the outcomes set out within:

- Our Health, Our Care, Our Say: making it happen. DH (2006)
- End of Life Care Strategy (2008) - Co-ordination of care is one of the most important aspects of the End of Life Strategy.
- Commissioning for Health and Wellbeing Framework. DH (2007)
- NHS NE – Our Vision, Our Future (2008)

The Marie Curie Delivering Choice Programme has consistently highlighted the need to improve coordination of care throughout the country, as part of an integrated model, which will reduce the time spent by clinical staff organising packages of care, allowing time to be reinvested into the delivery of care .

### 1.3 General Overview

The purpose of the service is to co-ordinate and arrange the planned care needs identified by a health or social care professional following clinical assessment of the patient and family/carers need.

### 1.4 Objectives

The overall objectives of the service specification are to:

- Improve the organisation and co-ordination of packages of care to benefit discharge processes and community care, that potentially will have an impact on avoiding hospital admissions and reduce length of stay.
- To provide a central point of communication about care packages for professionals, patients their families and carers
- Reduce the amount of time spent by clinical staff organising packages of care, allowing time to be reinvested into the delivery of clinical care
- Improve continuity of care through a co-ordinated approach to provision
- To provide equity in the booking of care packages across all professional groups.
- Promote integrated working across health and social care professionals
- To co-ordinate funding of palliative services and end of life providers ensuring the available resources and demand are optimised
- Effectively manage resources to ensure appropriate risk management, equity of available services equity of access to services and value for money
- Maintain a locality wide palliative care register
- Provide information and signposting to services to professionals
- Provide management information related to demand for care and unmet need

### 1.5 Expected Outcomes

The key outcomes that the proposed service will deliver are:

- A reduction in the time spent by clinical staff organising packages of care, allowing time to be reinvested into the delivery of care.

- Better organisation and coordination of packages of care will benefit discharge processes and community care, that potentially will have an impact on avoiding hospital admissions and reduce length of hospital stay
- Improved continuity of care for the patient through a coordinated approach to care provision
- Improved communication relating to packages of care between organisations and the patient and their carers/families that will potentially reduce anxiety
- A reduction in the number of double bookings or duplication of visits to a patient through clearer planning and information sharing
- A centrally held database capturing the care provision required by palliative care patients
- A centrally held database capturing information relating to demand for care; and unmet care
- A centrally held database capturing who is a known palliative care patient and their preferred place of care and actual place of care
- Improved communication between health and social care professionals and providers of care
- A coordinated approach to better information and signposting on services to both patients/families and professionals

## 2. Scope

### 2.1 Service Description

The co-ordination centre will provide the following services:

- **Organise and maintain packages of care** for palliative care patients related to the following services:
    - Community Nursing Teams – identify (planned care)
    - Out of Hours Palliative Care Team – identify (planned care)
    - Social care
    - Marie Curie Nursing Service
    - Nursing care from a nursing agency
    - Care home placements
    - Community Loan Equipment
    - Transport (to and from hospital and hospice)
    - Admission to community hospitals and hospices
- Establish, maintain and review the **Locality end of life care register** including information on preferred place of care and death
- Provide commissioners and providers with **information relating to demand and capacity of services**
- **Coordination of information regarding palliative care services** across your locality and providing a signposting function to professionals.
- **A central point of communication relating to care packages** for palliative care patients to health and social care professionals

### Assessment and Care Planning

All patient and carer assessments will be carried out by an appropriate professional and the assessment identified care needs will be communicated to Palliative Co-ordination Centre to enable them to arrange planned care in an effective and timely manner.
The referrer will identify:

- Patient assessment and information required for all potential care providers
- Patient and carer need and preferences
- The length and frequency of visits and when they are required e.g. night or day care.
- The grade of staff required. E.g. qualified or unqualified
- Any special or individual requirements

The service will be expected to work in ways which are sensitive to social, cultural and spiritual requirements of each patient and their carers. This will include access to translation and interpreting services.

**2.2 Accessibility/acceptability**
The Service will provide accessibility criteria to demonstrate activities noted above and delivery of the service on a X day week basis on an equitable basis across your locality. The operating hours of the service should be determined in line with local service provision and demand.
An example of operation hours could be: The service will operate between the hours of 8am-6pm Monday to Friday, with additional hours on Saturday and Sunday 10am-3pm to address urgent care arrangements.

**2.3 Whole System Relationships**

The Palliative Care Co-ordination Service will ensure that services are used efficiently and effectively by building good relationships between all care providers. This transparent and trustful relationship will allow for flexibility and integrated working across service providers to meet unplanned need and the challenges of providing end of life care in a community setting. The Palliative Care Co-ordination Centre's success will be reliant on excellent working relations with health and social care professionals across your locality and it is expected that good working relationships will be developed with all providers of end of life care across the locality.

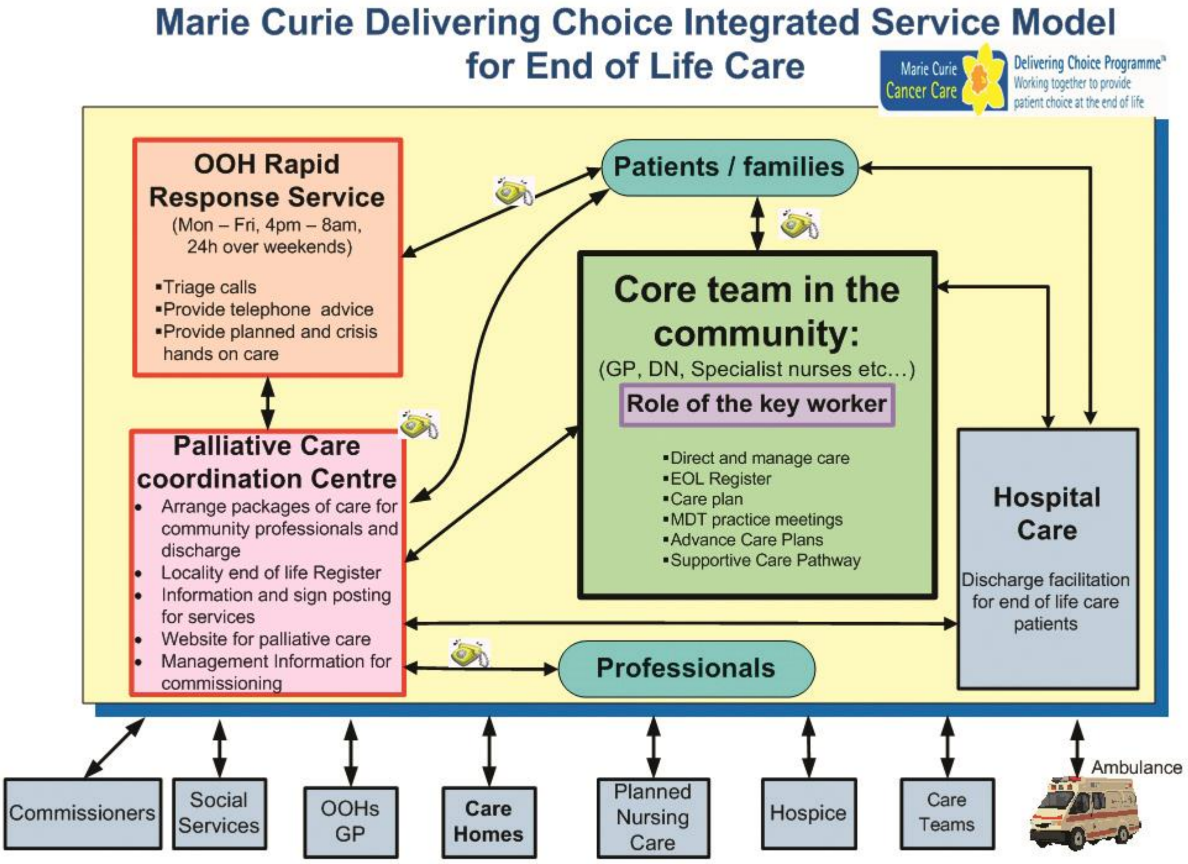
In addition to the patient and his/her carers, key relationships will include primary and secondary care, social care and the voluntary sector. The service will be well co-ordinated and flexible to ensure that service users and carers receive efficient and effective delivery of services.

For the service to be effective it is vital that it is integrated with all providers of palliative and end of life care. This includes, but is not limited to:

- Patient's key worker
- GPs
- Community Nursing
- Out Of Hours (OOH) GP provision
- Specialist Palliative Care Service
- Local hospice and care homes
- Ambulance Service
- Acute services including hospital discharge and Occupational Therapy
- Social Services
- Continuing Care Team
- Hospital Discharge Team
- Other agencies involved in patient care

These relationships will be primarily brokered through the Palliative Care Co-ordination Centre although all those delivering care to the patient and their carer will be involved.

**The Marie Curie Delivering Choice Integrated Service model for end of life care is an example of how high quality end of life care can be delivered using a whole systems approach.**

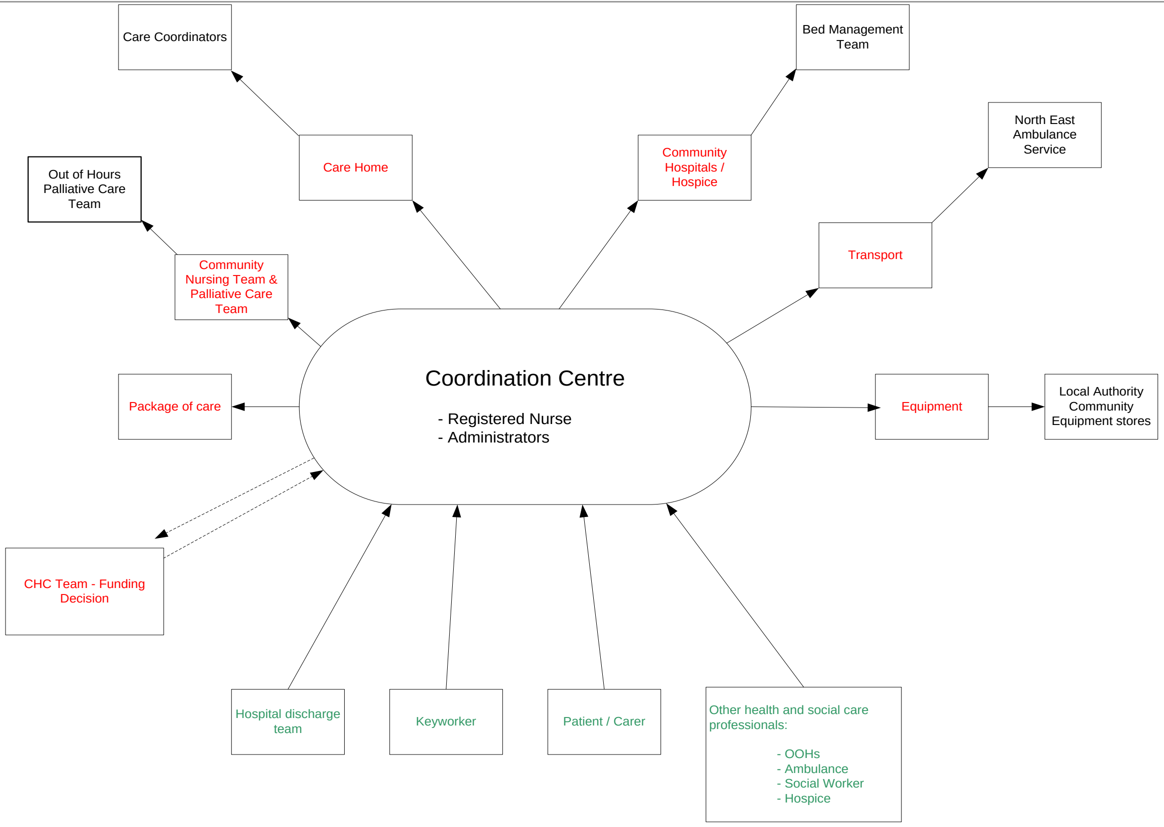


**2.4 Interdependencies**

The provider will be expected to establish positive working relationships with other providers including local authorities, social services, the independent sector and the voluntary sector to ensure that patients receive a comprehensive health and well being service.

The diagram below demonstrates the intended interactions between the coordination centre and other organisations.

The integrated service that the individual and carer receive must be seamless and must not be fragmented or duplicated.



### 2.5 Sub-contractors

However services are configured or delivered by agencies other than that directly employed by one provider; they must adhere to the service principles and aims. This can include a formal partnership agreement with accountability and governance arrangements in place.

## 3. Service Delivery

### 3.1 Service model

The Palliative Care Co-ordination Centre will have a single point telephone number and will be based to ensure efficient operation. There will be clear guidelines about the software that will be used to manage:

- Recording of patient details / clinical assessments / care required / PPC / DNAR etc.
- Source of referral
- Provider
- Arrangement of care packages
- Arrangement / booking equipment
- Funding arrangements
- Number of requests / number of cancellations etc.

The anticipated demand for the service is difficult to predict as is based upon local patient need. Data collated by the delivering choice programme is available for the Co-ordination Centres that have been established as part of the partnership programme. Length of calls and time needed to arrange care packages will vary significantly. Evidence from previous co-ordination centre interventions suggest that the average call/time to arrange a package of care is 3-4 hours and is dependent upon complexity and individual needs of the patient. In addition to this estimation the average length of call for first referral is approximately 1 hour. There will also be 1 hour per month for maintenance of each package and additional time factored in for maintenance of register etc.

It is important to note that this is only estimation and will vary dependent on local need.

It is expected that the team should include clerical staff who are trained in the use of IT systems that the co-ordination centre will use. These are:

- The Locality Palliative Care Register
- A Scheduling system

It is also expected that the PCCC will have access to clinical advice and support at a management level; this may be through the team leader having clinical skills.

The key skills and competencies expected include the following:

- Good communication skills
- Ability to build relationships and credibility quickly.
- Ability to communicate with both service providers, patients and carers in a dignified and clear manner
- IT skills and the ability to work with technology in a multitasking environment
- Ability to prioritise and co-ordinate workload, solve problems and take proactive actions to address issues
- Experience in call centre or similar environment
- Experience in dealing with customers / patients

The service must ensure that they are appropriately equipped with accommodation, equipment and IT equipment that can facilitate the co-ordination and booking of simple and complex packages of care.

It will be a requirement of the provider to maintain records of care booked and to share this information with the commissioners to allow for effective monitoring of service performance.

It is essential that the following standards are met by the service

- To maintain appropriate, contemporaneous records of patients referred to the Palliative Care Co-ordination Centre
- To communicate and provide information that is coherent and is in line with the commissioners policies, the Department of Health Code of Confidentiality, The Caldecott report, Data Protection Act 1998, local child and adult protection procedures and should outline the mechanisms to safeguard patient information when shared within an integrated service.
- Patient information will be stored securely in accordance with all governance procedures.
- To communicate effectively with multidisciplinary teams of health and social care professionals who will deliver services required. These teams work in different ways, dependent on setting and individual needs.

### 3.2 Care Pathways

Care pathways will be individual to reflect each person’s needs and in context with the principles of the End of Life Strategy.

These pathways will reflect the utilisation of a patient informed, choice integrated, delivery model through the care planning process and aspirations of the patient through personal health plans/ Preferred Priorities of care.

The aims of care planning and care co-ordination, which all clinical providers will be expected to deliver are to:

- Develop, manage and review documented care plans
- Ensure access to a comprehensive range of services

- Ensure the co-ordination of care across all agencies involved with the patient
- Ensure that there is continuity of care and that patients are followed throughout their patient journey.
- Avoid duplication of assessment and interventions
- Prevent patients `falling between services`

There should be a single multidisciplinary patient record system in which all members of the team record their interventions.

This will be in electronic form both for inpatient and outpatient services to facilitate smooth timely processing and utilisation of information.

A designated member of the team will be responsible for overseeing and coordinating the patient's care and acting as a point of communication between the Palliative Care Co-ordination Centre and the patient/family.

**Booking Care**

It is the responsibility of a clinical professional to conduct the patient and carer assessment. It is the responsibility of the assessing professional to make a referral for a care package, to the Palliative Care Co-ordination Centre. The Co-ordination Centre will then arrange for a care package to be delivered by a range of providers.

**The palliative care coordinator would inform the provider:**

- Whether an application has been made for Continuing Health Care (CHC) funding and whether it has been confirmed.
- Patient and carer need, e.g. social or health & the patient and carers preferences
- Patient assessment and information required for all potential care providers.
- The length and frequency of visit including whether it is night or day
- The grade of staff, e.g. qualified or unqualified carer, generalist or specialist palliative care service

**Co-ordination of Care**

- The palliative care coordinator would liase with the patient's key worker to ensure effective co-ordination across all teams and providers of care (including statutory, voluntary and independent sectors) who are involved in the care of patient and family

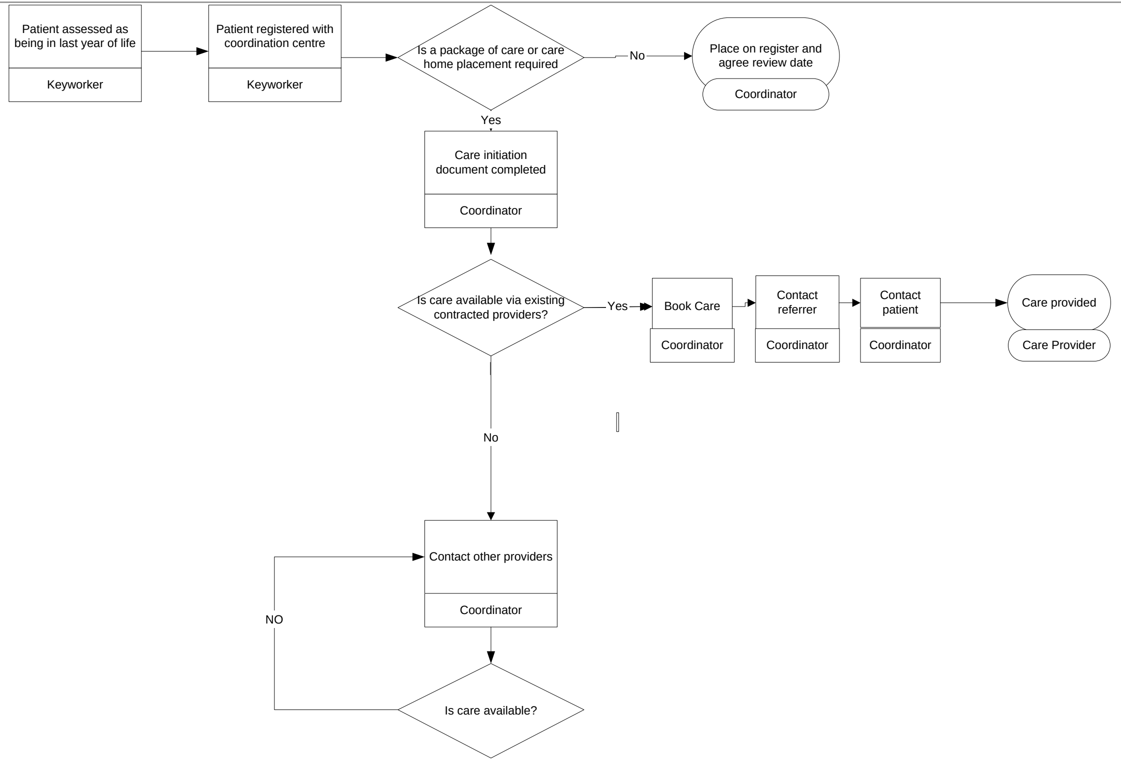
**Care after Death**

- The end of life care coordinator would inform all relevant agencies of the patient's death. This does not include any responsibility for registering the death.

**Patients and Carers experience**

- Phone contact with the end of life care coordinator who explains clearly and succinctly the care package including agreed providers, their name and time of visit
- At the end of the phone call, the patient and carer would be clear of the outcome, including (where appropriate) the timescale within which further action will be taken and any visits.
- Patient and carers can telephone the coordination centre to confirm details regarding their home

The diagram below demonstrates the intended process for arranging care packages including the interactions between the coordination centre and other organisations.



A process will need to be arranged in relation to the funding of care packages, this will require close liaison with the commissioning organisation.

## 4. Referral, Access and Acceptance Criteria

### 4.1 Geographic coverage/boundaries

The service will cover all patients who are registered with a NHS ________________ General Practitioner.

### 4.2 Location(s) of Service Delivery

The service will operate to cover the whole of your locality area with local knowledge of services available to meet the needs of the patients. The actual physical location of the service will be dependent of the selected provider organisation. However it the chosen provider will have to demonstrate comprehensive knowledge of local services provision and the local health and social care commissioning arrangements.

### 4.3 Days/Hours of operation

For example, a previously commissioned service operates between the hours of 8am-6pm Monday to Friday, with additional hours on Saturday and Sunday 10am-3pm. This example may or may not be relevant given the existing service provision and need of your area.

### 4.4 Referral criteria & sources

The referral criteria to the centre would be the following:

- The patient is eligible to go on the Primary Care end of life register (A clinician would answer “no” to the intuitive question integrating co-morbidity, social and other factors “Would you be surprised if this patient were to die in the next 6 – 12 months”, from the Prognostic Indicator Guidance.
- The patient is over 18 years old
- The patient is registered with a GP in your locality

Referrals will be taken for planned packages of care within the patient's normal place of residence. Packages of care can include social, nursing and respite care during the day or night. The service will have a pre-agreed, clear framework within which to work to ensure that the allocation of services is within locally agreed arrangements.

### 4.5 Referral route

Referrals will be taken from

- Key Worker (Primarily District Nurse)
- Acute discharge teams
- Community nursing Staff
- Specialist nurses
- Hospices
- General Practices
- Other individual referrers (to be agreed).

The Palliative Care Co-ordination Centre will advise that the individual referrer contacts the patient's community nurse for an assessment and to arrange care with the service. Where the patient is not known by the community nurse, the service will give advice on how to arrange an appropriate referral.

### 4.6 Response time & prioritisation

- During office hours, the coordination centre would respond to all referrals either immediately or within 30 minutes if the answer machine is on (Circumstances when the answer machine is permitted to be used will be agreed with the chosen provider). This delay should be exceptional.
- If a message is left during out of hours, the coordination centre would respond the next working day
- The coordination centre would triage messages and deal with urgent calls as a matter of priority. A model for triaging calls will be agreed with the chosen provider.
- For inappropriate referrals, the coordination centre would signpost the referrer to more appropriate services

### 4.7 Key patient data collection

The following data will be provided on a monthly basis as a minimum:

All patients

- New Patients – numbers of patients that were referred for the first time ever during the month
- Source of referral, i.e. community nurses, discharge community link nurse.
- Geographic location of patient: identified via the patients postcode
- Total number of patients – The number of patients that require care packages over consecutive months. Ensuring patients are not double counted
- Number of inappropriate referrals
- Number of care changes to existing packages

Patient analysis – (using the guidance from National Council for Palliative Care Minimum Data Set)

- Lives alone
- Age and gender
- Diagnosis
- Analysis of primary diagnosis

- Ethnicity

Visits

- Number of requests for visits
- Requested Hours, frequency and grade of staff, e.g. RN, HCA,SW, Social Care staff
- Delivered Hours, frequency, grade of staff meeting need and providing organisation
- If grade of staff different to that requested, reason, e.g. RN identified but none available so lower grade booked
- Unmet need and reason, timing of the shift

Cancellation of visits

- Number of visits cancelled
- Reason
- Timing of cancellation, e.g. to capture reason and consequence, e.g. cancellation fee for late cancellation, late identification of care package, patient death

Coordination centre activity

- Number of calls to centre
- Time to respond to call
- Time taken to complete care booking

User feedback

- Professional satisfaction questionnaire (including care providers)
- Patient/carer satisfaction questionnaire

Patient outcome

- Patient preferred place of care
- Carer preferred place of care
- Actual place of death
- Length of time on register

## 5. Discharge from the service

Active Patient details, including any associated records will be kept by the service until the patient dies. (**NHS Record Keeping / Data Protection)** It is the responsibility of the attending clinician to inform the service when a patient has died to ensure that the Palliative Care Co-ordination Centre informs all agencies of the need to end the care package. Where this is outside of the operational hours of the Palliative Care Co-ordination Centre it is the responsibility of the attending clinician to cancel care packages direct and to communicate this to the Palliative Care Co-ordination Centre.

## 6. Patient and Carer Information

Patients and Carers experience;

- Phone contact with the end of life care coordinator who explains clearly and succinctly the care package including agreed providers, their name and time of visit
- At the end of the phone call, the patient and carer would be clear of the outcome, including (where appropriate) the timescale within which further action will be taken

and any visits.

- Patient and carers can telephone the coordination centre to confirm details regarding their home care package

## 7. Quality and Performance Standards -

### National Standards, Guidance, Targets and Requirements

Commissioners expects that the Provider will comply with all national quality requirements as s out within *Standards for Better Health* and *Essence of Care*. e.g.

- Privacy and Dignity
- Principles of Self Management (embedded within this is Self Management Programmes)
- Recordkeeping

The Care Quality Commission carries out a series of reviews each year including reviews of clinical areas and reviews of developmental standards. Your locality commissioners expect the Provider to work with _________________ in aspiring to achieve a “good” or “excellent” rating in any such review.

The Provider should comply with all Department of Health (DH) and NHS guidance on accepted current and future best practice, including NICE guidance. Where the Provider has deviated from any national or locally agreed clinical guidance, the Provider is required to update local commissioners in writing at the earliest opportunity at the Clinical Review Meeting, along with the reasons for non-compliance.

### Clinical Quality Performance Indicators and Consequences

- Local commissioners will monitor the Provider on all items within the performance indicator included in the contract:
- Commissoners expect that the Provider will provide information in the format and frequency specified in order to support this monitoring. The Provider shall produce monthly Clinical Quality Performance Report, detailing performance against the agreed schedule. Reports will be reviewed at the monthly Clinical Quality Review Meetings.

### Infection Control

- NHS ______________ expects the Provider to comply with the *Code of Practice for the Prevention and Control of Healthcare Associated Infections* and implement best practice from *Saving Lives* in respect to hand hygiene.
  In the event of any potential infectious risk the provider will work with the Health Protection Agency (HPA) where clinical priorities will take precedence

### Safety and incidents

- The Provider is responsible for ensuring the safety of patients whilst on their premises, under the care of their staff and departments and throughout the discharge process. Local commissioners expect that the provider have robust risk management systems in place including incident reporting and learning, and risk assessment and management. NHS - ___________ requires the Provider to share action plans resulting from incidents, assessed as high risk but which fall outside the SUI process, with NHS ___________ for agreement at monthly Clinical Review Meetings.

- NHS ______________ requires that the Provider supplies it with a quarterly report of the total number of incidents by division. NHS _____________ will be looking for assurance that the proportion of serious incidents is not increasing, in line with best practice in the embedding of a safety culture.
- NHS ___________ expects that the Provider will comply with the arrangements for notification and investigation of Serious Untoward Incidents (SUIs) as set out in Appendix 3 (*Serious Untoward Incidents and Patient Safety Incidents*)
- NHS ____________ expects that a senior manager from Governance will attend a quarterly Patient Safety and Quality Network meeting with other key stakeholders in order to share learning across the health economy.
- NHS ___________ expects the Provider to notify NHS ____________ of the number and type of any drug errors by division and ward and to share any learning and resulting action plans with NHS _____________ at the Clinical Review Meetings.

**Care of the Client**

The Provider will:

- Ensure that cultural, religious, and life style beliefs are respected at all times
- Regard the physical and mental health needs of all members of the household at all times

**Audit**

- The Provider is expected to have, in place, an annual programme of audit and effective systems to support audit, implement changes and share findings. NHS________ requires to be invited as a member of the Clinical Audit Committee and receive all agendas, minutes and papers. NHS ______________ must receive a copy of the Annual Audit Plan and Annual Audit Report. All specific individual audit reports and findings should be available to NHS __________ on request within 30 days of request and to aid this, NHS ______________ should be provided with a quarterly list of completed audits, outcomes and lessons learnt.
- In agreement with NHS ____________ the providers will include within their annual audit plan areas of audit in response to the Institute for Innovation and Improvement “Delivering Quality and Value” in the following areas

**Compliments, Complaints and PALS**

- The Provider is expected to have in place services that meet the requirements of the NHS Complaints Process and the PALS agenda. In addition, the Provider should be learning from specific events and trends analysis. NHS _________________ expects the Provider to produce a quarterly report of the total number of complaints and the response rate, by division; and a report on the total number of PALS enquiries by division. The provider should also report the number of PALS enquiries which are recorded as complaints
- NHS _________________ expects that, in line with good practice, the Provider grades all formal complaints, and this grading is reflected in the quarterly reports
- NHS _____________ expects that the Provider will segment the complaints using a

categorisation agreed with NHS ______________ and will report the top three areas of complaint each quarter. NHS ___________________ requires evidence of an action plan in place, agreed with NHS _________________ through Clinical Review Meetings, to address as a minimum those areas raised as most common issues of concern in the previous year.

**Patient Experience**

- NHS _________________ aims to ensure that information about patient experience is used systematically to support commissioning. NHS _____________ expects that the Provider will give patients the opportunity to comment on their experience of using services on an ongoing basis, through patient surveys, Patient and Public Involvement work, PALS, complaints and other activities.
- The Provider will provide NHS ________________ by the end of quarter one a detailed plan of how it intends to deliver this expectation over the following 12 months.
- The Provider will ensure they collect equality and diversity monitoring information in accordance with the requirements within Standards for Better Health and will provide these to NHS _________________ if requested to do so.

**Patient-reported outcome measures**

- NHS ________________ and the Provider will work together during the first quarter of the contract period in agreeing further outcomes measures and indicators to be included in the Contract.

**Safeguarding Adults**

- NHS _________________expects the Provider to work within the Safeguarding Policies in place across ________________(to include the local authority areas of_________________________)

**Working Together**

It is expected that the Provider will participate where appropriate in developing end of life services.

**Accountability structures**

- All team members to have an annual appraisal and personal development plan.
- Continuing professional development must be actively encouraged through:
    - In-service training
    - Formal course attendance

**Team leader:**

- Reflective practice
- Clinical supervision
- Mentoring and clinical reasoning/problem solving sessions.-

Each team will be led by a team leader with clinical skills.

- There must be clear lines of accountability and responsibility
- Leadership development occurs at all levels of the organisation.
- The teams will meet regularly to ensure there is effective communication between members of the team and between the team and other agencies to ensure that patient needs are met

- Multi-skilling within the team will be encouraged and organised
- Each team will focus on the allocation of tasks, time management and work methods
- Team members will be involved in the recruitment of other members of the team.

The service will make available any information as reasonably required by _____________ for the purposes of monitoring the service specification.

## 8. Activity

| ***Activity Performance Indicators*** | ***Threshold*** | ***Method of measurement*** | ***Consequence of breach*** | ***Report Due*** |
|---|---|---|---|---|
| Number of referrals to Palliative Care Co-ordination Centre from<br>(i) Patient or carer<br>(ii) GPs<br>(iii) Emergency Care Practitioner<br>(iv) Hospital staff<br>(v) District Nurse<br>(vi) OOH's Call Centre<br>(vii) Specialist palliative care<br>(viii) Clinical Nurse Specialists (Specialist Palliative Care, Heart Failure Nurses Etc.)<br>(ix) Community Matrons<br>(x) Other health care professionals | | Through monthly report generated by service monitoring software | | |
| Total number of patients that received services in the month broken down by<br>(i) Patients that have used the service before<br>(ii) New referrals | | Through monthly report generated by service monitoring software | | |
| Type of referrals to Palliative Care Co-ordination Centre broken down by<br>Planned<br>(i) Visits<br>(ii) Phone advice | | Through monthly report generated by service monitoring software | | |
| Type of referrals to Palliative Care Co-ordination Centre broken down by Emergency or urgent<br>(i) Visits<br>(ii) Phone advice | | Through monthly report generated by service monitoring software | | |

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|---|---|---|---|---|
| Average response time from referral to registration for PCCC (in minutes) | | Through monthly report generated by service monitoring software | | |
| Average time for arrangement of packages of care<br>(i) New referrals<br>(ii) Changes to existing patients | | Through monthly report generated by service monitoring software | | |
| Length of planned telephone advice<br>(i) Total hours / month<br>(ii) Average minutes / visit | | Through monthly report generated by service monitoring software | | |
| Length of urgent telephone advice<br>(i) Total hours / month<br>(ii) Average minutes / visit | | Through monthly report generated by service monitoring software | | |
| Primary diagnosis broken down by condition with summary for number of patients with<br>(i) Cancer<br>(ii) Heart disease<br>(iii) Respiratory Disease<br>(iv) Other | | Through monthly report generated by service monitoring software | | |
| Secondary diagnosis broken down by condition | | Through monthly report generated by service monitoring software | | |

## 9. Continual Service Improvement Plan

As part of the monitoring and evaluation process, this service will identify methods of agreeing measurement for continuously improving the service being offered and work to ensure that any unmet needs are identified and brought to the attention of commissioners.

The service model proposed, aims to complement the joint working between organisations and link with these existing services. The coordination centre success would be reliant on excellent working relations with the health and social care professionals across _____________ and therefore further development and implementation of the centre would include consultation with local organisations.

## 10. Prices & Costs

### 10.1 Price

| Basis of Contract | Unit of Measurement | Price | Thresholds | Expected Annual Contract Value |
|---|---|---|---|---|
| Block/cost &volume/cost per case/Other________* | | £ | | £ |
| | | | | |
| Total | | £ | | £ |

***delete as appropriate***

### 10.2 Cost of Service by commissioner

| Total Cost of Service | Co-ordinating PCT Total | Associate PCT Total | Associate PCT Total | Associate PCT Total | Total Annual Expected Cost |
|---|---|---|---|---|---|
| £ | £ | £ | £ | £ | £ |